U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Winter 2012/13
Denver Regional Office

The Pulse of CMS

"A quarterly regional publication for health care professionals"
Serving Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming.

PRESIDENT OBAMA SIGNS THE AMERICAN TAX PAYER RELIEF ACT

President Obama Signs Tax Payer Relief Act

On Wednesday, January 2, 2013, President Obama signed into law the ***American Taxpayer Relief Act of 2012***. This new law prevented a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect on January 1, 2013. The new law provides for a zero percent update for such services through December 31, 2013. This provision guarantees seniors have continued access to their doctors by fixing the Sustainable Growth Rate (SGR) through the end of 2013. President Obama remains committed to a permanent solution to eliminating the SGR reductions that result from the existing statutory methodology. The Administration will continue to work with Congress to achieve this goal.
The new law extends several provisions of the *Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act)* as well as provisions of the *Affordable Care Act*. Specifically, the following Medicare fee-for-service policies (with January 1, 2013, or October 1, 2012, effective dates) have been extended. We also have included Medicare billing and claims processing information associated with the new legislation. Please note that these provisions do not reflect all of the Medicare provisions in the new law, and more information about other provisions will be forthcoming.

Section 601 – Medicare Physician Payment Update: The new law provides for a zero percent update for claims with dates of service on or after January 1, 2013, through December 31, 2013. CMS is currently revising the 2013 Medicare Physician Fee Schedule (MPFS) to reflect the new law's requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2013 conversion factor is $34.0230. In order to allow sufficient time to develop, test, and implement the revised MPFS, Medicare claims administration contractors may hold MPFS claims with January 2013 dates of service for up to 10 business days (i.e., through January 15, 2013).

The 2013 Annual Participation Enrollment Program allowed eligible physicians, practitioners, and suppliers an opportunity to change their participation status by December 31, 2012. Given the new legislation, CMS is extending the 2013 annual participation enrollment period through February 15, 2013. Therefore, participation elections and withdrawals must be post-marked on and before February 15, 2013. The effective date for any participation status changes elected by providers during the extension remains January 1, 2013.

Section 602 - Extension of Medicare Physician Work Geographic Adjustment Floor : The 2012 1.0 floor on the physician work geographic practice cost index is extended through December 31, 2013. As with the physician payment update, this extension will be reflected in the revised 2013 MPFS.

See Relief Act Page 4

Inside this Issue...

Looking Back at ICD-10 and Ahead

Last year all practices covered by HIPAA were required to upgrade from Version 4010 to Version 5010 standards for electronic health care claims and other transactions. The Version 5010 upgrade paved the way for ICD-10 and offers valuable insights:

Early planning and preparation will smooth your transition to ICD-10. Practices that planned for the Version 5010 upgrade were well prepared and transitioned smoothly. For ICD-10, your office can start planning by developing a checklist of activities that will need to be completed and a timeline for accomplishing these tasks.

Communication and coordination must occur not only in your office, but also between your practice and the trading partners you conduct business with software vendors, clearinghouses and billing companies, commercial and government health plans and other payers.

Risk mitigation is important to address any disruptions that may occur as your practice transitions to ICD-10. You may want to consider planning for possible short-term cash flow disruptions and for securing the services of billing companies or clearinghouses.

See Looking Ahead: ICD-10 Page3

Major Improvements to PECOS

Over the last year, CMS has listened to your feedback about Internet-based PECOS and made improvements to increase access to more information. Providers/suppliers now have an easier way to view their enrollment information. PECOS will display the following information:

-View Approved Enrollment Record – displays the provider/supplier's finalized enrollment information in PECOS,

-View Submitted Application – displays the provider/supplier's enrollment information pertaining to the last electronic submission, and

-View New or In-Progress Applications – displays the provider/supplier's enrollment information as its being edited in PECOS

The provider/supplier can access their enrollment information from the My Enrollments page. The information will display in an HTML view and can be saved and, or printed by the provider/supplier. (*Note:* The CMS-855 PDF forms are no longer available and have been replaced with the new HTML views.)

The enrollment tutorial videos, located on the PECOS home page, have been updated to illustrate the most common enrollment scenarios completed by providers/suppliers.

A new part B provider service has been established for Centralized Flu Billers. In addition, the centralized flu biller approval letter has been added as a type of required/supporting documentation for a CMS 855B enrollment application. Centralized flu biller enrollment applications submitted via PECOS will be routed to Novitas Solutions, who is the designated Medicare Administrative Contractor.

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PROVIDERS FORM 106 NEW ACOs

Doctors and health care providers have formed 106 new Accountable Care Organizations (ACOs) in Medicare, ensuring as many as 4 million Medicare beneficiaries now have access to high-quality, coordinated care across the United States. The announcement of the new Medicare Shared Savings Program (MSSP) ACOs was made by Health and Human Services (HHS) Secretary Kathleen Sebelius on January 10, 2013.

Doctors and health care providers can establish ACOs in order to work together to provide higher-quality care to their patients. Since passage of the Affordable Care Act, more than 250 Accountable Care Organizations have been established. Beneficiaries using ACOs always have the freedom to choose doctors inside or outside of the ACO. ACOs share with Medicare any savings generated from lowering the growth in health care costs, while meeting standards for quality of care.

ACOs must meet quality standards to ensure that savings are achieved through improving care coordination and providing care that is appropriate, safe, and timely. The Centers for Medicare & Medicaid Services (CMS) has established 33 quality measures on care coordination and patient safety, appropriate use of preventive health services, improved care for at-risk populations, and patient and caregiver experience of care. Federal savings from this initiative could be up to $940 million over four years.

The new ACOs include a diverse cross-section of physician practices across the country. Roughly half of all ACOs are physician-led organizations that serve fewer than 10,000 beneficiaries. Approximately 20 percent of ACOs include community health centers, rural health clinics and critical access hospitals that serve low-income and rural communities.

The announced group includes 15 Advance Payment Model ACOs, physician-based or rural providers who would benefit from greater access to capital to invest in staff, electronic health record systems, or other infrastructure required to improve care coordination. Medicare will recoup advance payments over time through future shared savings. In addition to these ACOs, last year CMS launched the Pioneer ACO program for large provider groups able to take greater financial responsibility for the costs and care of their patients over time. In total, Medicare's ACO partners will serve more than 4 million beneficiaries nationwide.

HHS has also issued a new report titled "Growth in Medicare Spending per Beneficiary Continues to Hit Historic Lows." The reports shows that Affordable Care Act provisions are already having a substantial effect on reducing the growth rate of Medicare spending. Growth in Medicare spending per beneficiary hit historic lows during the 2010 to 2012 period, according to the report.

The next application period for organizations that wish to participate in the Shared Savings Program beginning in January 2014 is summer 2013. More information about CMS' MSSP is available on the CMS MSSP webpage. The MSSP ACOs webpage contains the listing of the 106 ACOs.

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Substantial Savings Announced for the Next Round of DMEPOS Competitive Bidding

The Centers for Medicare & Medicaid Services (CMS) today announced new, lower Medicare prices that will go into effect this July in a major expansion of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. The CMS Office of the Actuary estimates that the program will save the Medicare Part B Trust Fund $25.7 billion and beneficiaries $17.1 billion between 2013 and 2022. Medicare beneficiaries in 91 major metropolitan areas will save an average of 45 percent for certain DMEPOS items scheduled to begin on July 1, 2013.

Medicare beneficiaries across the country will save an average of 72 percent on diabetic testing supplies under a national mail-order program starting at the same time.

A full list of the new prices is available at DME Competitive Bid web page. Medicare's competitive bidding program replaces its existing fee schedule amounts in selected areas with prices based on suppliers' bids, saving money for taxpayers and beneficiaries while preserving access to quality products from accredited suppliers.

Using market-based prices set through competition will help ensure the long-term sustainability of the Medicare program. Small businesses represent over half of the winning suppliers in these 91 metropolitan areas.

See DME Competitive Bidding Page 4

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CDC: "Take 3" Actions to Fight the Flu

The Flu is a serious contagious disease that can lead to hospitalization and even death. The Centers for Disease Control and Prevention (CDC) urges you to take the following three actions to protect yourself and others from influenza:

1.) Take time to get a flu vaccine.
- CDC recommends a yearly flu vaccine as the first and most important step in protecting against flu viruses. The vaccine will protect against an influenza A H3N2 virus, an influenza B virus and the H1N1 virus that emerged in 2009 to cause a pandemic.

-Vaccination of high risk persons is especially important to decrease their risk of severe flu illness. People at high risk of serious flu complications include young children, pregnant women, people with chronic health conditions like asthma, diabetes or heart and lung disease and people 65 years and older.

-Vaccination also is important for health care workers, and other people who live with or care for high risk people to keep from spreading flu to high risk people.

2.) Take everyday preventive actions to stop the spread of germs.
-Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it. Wash your hands often with soap and water. If soap and water are not available, use an alcohol-based hand rub. Additionally, avoid touching your eyes, nose and mouth. Germs can spread this way.

-If you are sick with flu-like illness, CDC recommends that you stay home for at least 24 hours after your fever is gone except to get medical care or for other necessities. (Your fever should be gone without the use of a fever-reducing medicine.) While sick, limit contact with others as much as possible to keep from infecting them.

3.) Take flu antiviral drugs if your doctor prescribes them.
-If you get the flu, antiviral drugs can treat your illness. Antiviral drugs are different from antibiotics. They are prescription medicines (pills, liquid or an inhaled powder) and are not available over-the-counter. Antiviral drugs can make illness milder and shorten the time you are sick. They may also prevent serious flu complications.

-Flu-like symptoms include fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills and fatigue. Some people also may have vomiting and diarrhea. People may be infected with the flu, and have respiratory symptoms without a fever.

Visit CDC's website to find out what to do if you get sick with the flu and how to care for someone at home who is sick with the flu.

Looking Ahead: ICD-10

Looking Ahead: ICD 10 from Page 1

Testing will need to be conducted within your office and with all payers and other companies you work with. You will need to begin ICD-10 testing in 2013 to allow for ample time to test multiple types of transactions, including claims. Share your ICD-10 plans with one another now to ensure you are on track to test at the same time. If you conduct electronic transactions and have not made the upgrade to Version 5010 standards, get a compliance plan in place right away.

You must use Version 5010 standards before your practice management or billing system can accommodate the structure of ICD-10 codes.

Keep Up to Date on ICD-10 by visiting the CMS ICD-10 website the latest news and resources to help you prepare. For practical transition tips, CMS recommends that you read our recent ICD-10 email update messages , and access the ICD-10 continuing medical education modules developed by CMS in partnership with Medscape. The deadline for ICD-10 is October 1, 2014.

DME Competitive Bidding

DME Competitive Bidding from Page 3

Importantly, the program has maintained beneficiary access to quality products from accredited suppliers in the nine areas where it is currently operating; extensive real-time monitoring data have shown successful implementation with very few beneficiary complaints and no negative impact on beneficiary health status based on measures such as hospitalizations, length of hospital stay, and number of emergency room visits compared to non-competitive bidding areas. CMS will employ the same aggressive monitoring for the MSAs added in Round 2.

In its first year of operation in the nine areas of the country where the program is currently operating, competitive bidding saved Medicare approximately $202.1 million. A complete list of the 91 areas where the program is expanding is available at DME Competitive Bid web page.

Additional information on the competitive bidding program is available at: DMEPOS Competitive Bidding web page .

Information Disclaimer:

The information provided in this newsletter is intended only to be general summary information to the Region III provider community. It is not intended to take the place of either the written law or regulations.

Links to Other Resources:

Our newsletter may link to other federal agencies. You are subject to those sites' privacy policies. Reference in this newsletter to any specific commercial products, process, service, manufacturer, or company does not constitute its endorsement or recommendation by the U.S. government, HHS, or CMS. HHS or CMS are not responsible for the contents of any "off-site" resource identified.

Tax Payer Relief Act

Tax Payer Relief ACT from Page 1

Section 603 - Extension Related to Payments for Medicare Outpatient Therapy Services - Section 603 extends the exceptions process for outpatient therapy caps through December 31, 2013. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through December 31, 2013. In addition, the new law extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD), and counts outpatient therapy services furnished in a Critical Access Hospital towards the cap and threshold. Additional information about the exception process for therapy services may be found in the *Medicare Claims Processing Manual*, Pub.100-04, Chapter 5, Section 10.3

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received on January 1, 2013. For physical therapy and speech language pathology services combined, the 2013 limit for a beneficiary on incurred expenses is $1,900. There is a separate cap for occupational therapy services which is $1,900 for 2013. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Section 603 also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2013 through December 31, 2013, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services, including OPD therapy services, for a year. There are two separate $3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services, and (2) occupational therapy services.

Section 604 - Extension of Ambulance Add-On Payments - Section 604 extends the following three *Job Creation Act* ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas is extended through December 31, 2013; (2) the provision relating to air ambulance services that continues to treat as rural any area that was designated as rural on December 31, 2006, for purposes of payment under the ambulance fee schedule, is extended through June 30, 2013; and (3) the provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus) is extended through December 31, 2013.

CMS is currently revising the 2013 Medicare Ambulance Fee Schedule (MAFS) to reflect the new law's requirements. In order to allow sufficient time to develop, test, and implement the revised MAFS, Medicare claims administration contractors may hold MAFS claims with January 2013 dates of service for up to 10 business days (i.e., through January 15, 2013).

Section 605 - Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals - The *Affordable Care Act* allowed qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This provision extends the payment adjustment through September 30, 2013, retroactive to October 1, 2012. Be on the alert for further information about implementation of this provision.

Section 606 - Extension of the Medicare-Dependent Hospital (MDH) Program - The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program until October 1, 2013, and is retroactive to October 1, 2012. Be on the alert for further information about implementation of this provision.